NOTICE OF INDEPENDENT REVIEW DECISION

September 30, 2002

RE: MDR Tracking #: M2-02-0838-01
IRO Certificate #: 4326

____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 42 year old female sustained a work related injury on ___ when she was lifting heavy objects and complained of cervical and shoulder pain. The patient has undergone an MRI and electromyography testing. Treatment has included pain medication, chiropractic care, biofeedback, physical medicine and rehabilitation, epidural steroid injections and TENS unit. The treating chiropractor has recommended that the patient undergo a 20 day multidisciplinary pain program.

Requested Service(s)

20 day multidisciplinary pain program.

Decision

It is determined that the 20 day multidisciplinary pain program is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicated that the patient in this case had an extensive course of conservative chiropractic treatments, physical medicine and rehabilitation, pain medications that included Vioxx and Vicodin, multiple rounds of epidural steroid injections, biofeedback, and a TENS unit. The psychological evaluation report dated 04/01/02 indicated that the patient still complained of pain at a level of /10 and she had also had individual psychotherapy. She was diagnosed with atypical depression, a psychological disorder associated with a medical condition, chronic pain, and moderate ongoing physical difficulties producing a disruption in her lifestyle.

Multidisciplinary programs are indicated when the patient has failed physical treatment programs for pain and/or has not demonstrated ample recovery through conservative medical treatments. In the case of chronic pain, treatments may require a multidisciplinary team for treatment as referenced in "Clinical Standards Advisory Group – Back Pain: Report of the CSAG committee on Back Pain", HMSO, 1994. Therefore, the 20 day program is medically necessary to treat this patient's condition.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,